

Mental Health Act Forms

Forms prescribed by regulation

(The content of these forms may not be altered other than to pre-insert recurring information, e.g. the name and address of the hospital).

Form

- 1 Statement of legal rights (to be given to involuntary patient on admission) – s30
- 2 Medical report as to mental state of a detained person – s29, s32
- 3 Notice of proceedings before Magistrate – s38(3)
- 4 Summons - Inquiry under Mental Health Act – s47(1)
- 5 Notification of Tribunal determination – s57
- 6 Appeal by patient against refusal to discharge – s69(1)
- 7 Appeal by a person other than the patient against refusal to discharge a patient – s69(1)
- 8 Rights to apply for review – persons admitted to hospital upon breach of CTO – s142(a)
- 9,10,11 Relate to Psychosurgery – not included.
- 12 Information and consent – ECT – s183, s185, s188
- 13 Notification to relative etc. of application to determine validity of consent to ECT – other than involuntary patients – s185, s190(1)
- 14 Notification to relative etc. of application to administer ECT – involuntary patients – s188, s190(1)
- 15 ECT Register. Available from the Centre for Mental Health
- 16 Notification to relative of intent to seek consent to surgery – s205(3)
- 17 Summons - Mental Health Review Tribunal – s278(1)
- 18 Oath of Assessor (to Supreme Court) – s282(2)(b) – not included
- 19 Psychiatric admissions advice to Mental Health Review Tribunal – s302(2)(m)
19 (A) Involuntary Psychiatric Referrals – s302(2)(m)
19 (B) Magistrates Inquiries – s302(2)(m)
- 20 Order or direction of Magistrate – Inquiry relating to mentally ill person

Forms used by the Centre for Mental Health

- CMH1** Personal application for informal admission to hospital
- CMH2** Application for informal admission to hospital of a person subject to a Guardianship Order
- CMH3** Application for review of decision of medical officer
- CMH4** Your rights after a Magistrate's Inquiry
- CMH5** Notice of discharge of person under guardianship
- CMH6** Application for variation/revocation of order
- CMH7** Request by member of NSW Police Service for admission of an alleged mentally disturbed person
- CMH8** Request by welfare officer for admission
- CMH9** Application for discharge from hospital
- CMH10** Application from relative of friend for patient's discharge from hospital
- CMH11** Breach of CCO – notice to patient
- CMH12** Breach of CTO – notice to patient
- CMH13** Transfer between hospitals of temporary or continued treatment patient
- CMH14** Transfer of an involuntary patient to an interstate mental health facility

Forms prescribed in the Mental Health Act 1990 (NSW)

- Schedule 2** Medical certificate as to examination or observation of person
- Schedule 3** Medical certificate as to examination or observation of person (Corrections Health only)

YOUR RIGHTS

You should read the questions and answers below to find out your rights and what may happen to you after you are brought to a hospital.

WHAT HAPPENS AFTER I ARRIVE AT HOSPITAL?

You must be seen by a hospital doctor not later than 12 hours after you arrive at the hospital.

If you are a person who is already in hospital as an informal patient, and you have been told you are now to be kept in hospital against your will, you must be seen by a hospital doctor not later than 12 hours after it is decided to keep you in hospital.

WHEN CAN I BE KEPT IN HOSPITAL AGAINST MY WILL?

You can be kept in hospital against your will if you are certified by the hospital doctor as a mentally ill person or a mentally disordered person. The doctor will decide whether you are a mentally ill person or a mentally disordered person.

A mentally ill person is someone who has a mental illness and who needs to be kept in hospital for his or her own protection or to protect other people. A mentally disordered person is someone whose behaviour shows that he or she needs to be kept in hospital for a short time for his or her own protection or to protect other people.

The hospital cannot continue to keep you against your will unless at least one other doctor also finds that you are a mentally ill person or a mentally disordered person. At least one of the doctors who sees you must be a psychiatrist.

HOW LONG CAN I BE KEPT IN HOSPITAL AGAINST MY WILL?

If you are found to be a mentally disordered person, you can only be kept in hospital for up to **3 DAYS** (weekends and public holidays are not counted in this time). During this time you must be seen by a doctor at least once every 24 hours. You cannot be detained as a mentally disordered person more than 3 times in any month.

If you are found to be a mentally ill person, you will be kept in hospital until you see a Magistrate who will hold an inquiry to decide what will happen to you.

HOW CAN I GET OUT OF HOSPITAL?

You, or a friend or relative, may at any time ask the medical superintendent to let you out. You must be let out if you are not a mentally ill person or mentally disordered person or if the medical superintendent thinks that there is other appropriate care reasonably available to you.

CAN I BE TREATED AGAINST MY WILL?

The hospital staff may give you appropriate medical treatment, even if you do not want it, for your mental condition or in an emergency to save your life or prevent serious damage to your health. The hospital staff must tell you what your medical treatment is if you ask. You must not be given excessive or inappropriate medication.

CAN I BE GIVEN ECT AGAINST MY WILL?

Yes, but only where the Mental Health Review Tribunal determines, at a hearing that it is necessary or desirable for your safety or welfare. You have a right to attend that hearing.

WHAT OTHER RIGHTS DO I HAVE IN HOSPITAL?

You can receive mail. You must not be ill-treated.

MORE INFORMATION

You should read the questions and answers below to find out about Magistrates' inquiries and when you may be kept in hospital against your will after an inquiry.

WHEN IS A MAGISTRATE'S INQUIRY HELD?

A Magistrate's inquiry must be held as soon as possible after it is decided to keep you in hospital against your will because you are a mentally ill person.

WHAT HAPPENS AT A MAGISTRATE'S INQUIRY?

The Magistrate will decide whether or not you are a mentally ill person.

If the Magistrate decides that you are not a mentally ill person, you must be let out of hospital. The Magistrate may make a Community Counselling Order requiring you to have certain treatment after you are let out.

If the Magistrate decides that you are a mentally ill person, the Magistrate will then decide what will happen to you. Consideration must be given to the least restrictive environment in which care and treatment can be effectively given. The Magistrate may order that you be kept in hospital as a **TEMPORARY PATIENT** for a set time (not more than 3 months) or the Magistrate may order that you be let out of hospital. If you are let out, the Magistrate may make a Community Treatment Order requiring you to have certain treatment after you are let out.

The Magistrate may adjourn the inquiry for up to 14 days where he or she considers that it is in your best interests.

If the Magistrate makes an order that you are to remain in hospital as a Temporary Patient, the Magistrate must also consider whether you are capable of managing your financial affairs. If the Magistrate is not satisfied that you are capable, an order must be made for management of your affairs under the *Protected Estates Act 1983*.

WHAT RIGHTS DO I HAVE AT A MAGISTRATE'S INQUIRY?

You can tell the Magistrate what you want or have your lawyer tell the Magistrate what you want. You can wear street clothes, be helped by an interpreter and have your relatives and friends told about the inquiry. You can apply to see your medical records.

WHAT ARE MY RIGHTS OF APPEAL IF I HAVE BEEN MADE A TEMPORARY PATIENT?

You (or a friend or relative) may at any time ask the medical superintendent to discharge you. If the medical superintendent refuses or does not respond to your request within 3 working days, you (or a friend or relative) may lodge an appeal with the Mental Health Review Tribunal.

You will be given a notice setting out your appeal rights.

WHAT HAPPENS WHEN THE TIME SET BY AN ORDER MAKING ME A TEMPORARY PATIENT HAS NEARLY ENDED?

The hospital medical staff will review your condition before the end of the order and the hospital may either discharge you or apply to the Mental Health Review Tribunal for a further order.

The Tribunal must let you out of hospital if it decides that you are not a mentally ill person or if it feels that other care is more appropriate and reasonably available.

WHO CAN I ASK FOR HELP?

You may ask any hospital staff member, official visitor, chaplain, your own lawyer or the Mental Health Advocacy Service for help. The Mental Health Advocacy Service telephone number is 9745 4277.

MEDICAL REPORT AS TO MENTAL STATE OF A DETAINED PERSON

This report is made as:

a certificate of the opinion of the medical superintendent after examination of a person under section 29 of the Act (initial examination)

OR

advice by a medical practitioner to a medical superintendent under section 33 of the Act (further examination)

(tick whichever is appropriate)

I, the undersigned, a registered medical practitioner, on _____
(date)

personally examined _____
(patient's name)

a person detained at _____
(hospital)

In my opinion, the person named above:

is not a mentally ill or mentally disordered person

OR

is a mentally ill person

OR

is a mentally disordered person

(tick the one box that is appropriate)

The basis for my opinion is as follows:

** (Reported behaviour of the patient)

(Reverse of Medical Report as to Mental State of Detained Person)

(Observations by me of the patient)

(Conclusion)

Name of medical practitioner: _____

Qualifications as a psychiatrist (if applicable): _____

(Signature)

(Date)

Note that this report is for the use of a legal tribunal and therefore should not be written in technical medical language.

INQUIRY-MENTAL HEALTH ACT 1990

Hospital _____

Address _____

NOTICE OF PROCEEDINGS BEFORE MAGISTRATE

Dear _____

I wish to advise you that _____
is at present a patient at this hospital under the provisions of the *Mental Health Act 1990*.

On _____ at approximately _____ a visiting
Magistrate will hold an inquiry at _____ to
consider whether or not further detention for the purpose of treatment is warranted.

You are invited to attend this enquiry. With the permission of the patient and the Magistrate, any person at all may represent the patient. However the patient will be legally represented unless the patient decides that he or she does not want to be. Should it be necessary, a competent interpreter will be available to assist.

If the Magistrate considers further detention is warranted the Magistrate will also consider whether or not the patient is able to manage his or her affairs. If the Magistrate considers that the patient is able to do so, then the patient will continue to do so. If the Magistrate is not satisfied that the patient can manage his or her affairs, then an order will be made that the Protective Commissioner manage the patient's affairs.

If the patient does not agree that his or her affairs should be managed by the Protective Commissioner, the patient may appeal to the Supreme Court.

If you have any questions, please feel free to discuss them with the patient's doctor or social worker. Contact may be made by telephoning _____.

Yours faithfully,

(Medical Superintendent)

(Date)

SUMMONS
Inquiry under Mental Health Act 1990

Hospital _____

Address _____

To: _____

A Magistrate will be holding an inquiry under the *Mental Health Act 1990* in relation to

(patient's name)

The inquiry will be held at approximately _____ on _____
(time) (date)

at the above address.

You are required:

* to attend the inquiry as a witness

* to attend the inquiry to produce the following documents:

(* delete if inapplicable)

You are entitled to receive reasonable costs, including loss of earnings incurred through compliance with this summons.

Should you fail or refuse to comply with this summons properly served, you may be guilty of an offence under the *Mental Health Act 1990*.

If you are required to attend the hearing only to produce documents, it is sufficient compliance with this summons if those documents are delivered to

_____ at _____
(address)

on or before _____

(signature)

(name)

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 5

(Cl.14)

MENTAL HEALTH ACT 1990
Section 57 (6)

DETERMINATION OF TRIBUNAL

(patient's name)

was brought before the Mental Health Review Tribunal on _____ (Date)

under provisions of section 56 of the Mental Health Act 1990.
The Tribunal determined that the patient:

* be **DISCHARGED** from hospital

* be **DETAINED** as a temporary treatment patient from _____ (Date)

until no later than _____ for further observation or treatment or both
(Date)

* be classified as a continued treatment patient and detained in hospital for further observation or treatment or both.

(* delete whichever is inapplicable)

Signed by the members of the Tribunal on _____ (Date)

(Member)

(Member)

APPEAL BY PATIENT AGAINST REFUSAL TO DISCHARGE

The Registrar
Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111

My name is _____ .

I am:

- a temporary patient
- a continued treatment patient

at _____ .
(name of hospital)

I have applied to the medical superintendent for discharge under section 67 (1) of the *Mental Health Act 1990*.

I want to appeal to the Mental Health Review Tribunal against the Medical Superintendent's:

- refusal to discharge me
- failure to make a determination on my application for discharge within 3 working days after I made the application.

(Tick one box only)

Signature _____ Date _____

APPEAL BY A PERSON OTHER THAN THE PATIENT AGAINST REFUSAL TO DISCHARGE A PATIENT

This appeal relates to _____
(patient's name)

who is:

- a temporary patient
- a continued treatment patient

(Tick one box only)

at _____
(name of hospital)

An application was made to the medical superintendent for discharge of the patient under section 67 or 68 of the Mental Health Act 1990.

My name is _____
(name of appellant)

I am:

- the applicant for discharge of the patient
- a person appointed by the patient.

(Tick one box only)

I want to appeal to the Mental Health Review Tribunal against the Medical superintendent's:

- refusal to discharge the patient
- failure to make a determination within 3 working days after the application for discharge of the patient.

(Tick one box only)

Signature _____ Date _____

RIGHTS TO APPLY FOR REVIEW

To _____
(patient's name)

On _____ it was ordered under section 139 of
(date)

the *Mental Health Act 1990* that you be taken to a hospital or health care agency as a result of breaching your Community Treatment Order. You may have been taken directly to the hospital or you may have been taken to the hospital only after you refused treatment at a health care agency.

YOU HAVE THE FOLLOWING RIGHTS

You may discuss your rights of appeal with a social worker, doctor, official visitor or your own lawyer, or with the Mental Health Advocacy Service whose legal advice is free.

1. You may apply to the Mental Health Review Tribunal to have the Community Treatment Order varied or revoked.
2. You may lodge an appeal against the Order with the Supreme Court or, where the order was made by a Magistrate, the Mental Health Review Tribunal.
3. You may ask the Medical Superintendent to discharge you from the hospital.
4. You may get a relative or friend to apply to the Medical Superintendent for your discharge, if the person will give an undertaking that you will be properly taken care of and will be prevented from causing harm to yourself or others. This application may be made orally or in writing. It would be to your advantage to make such an application in writing.

FORMS 9, 10 AND 11 DEAL WITH PSYCHOSURGERY

Form 9 – Information and Consent

Form 10 – Application to Perform Psychosurgery

Form 11 – Summons (for attendance of persons or production of documents)

INFORMATION AND CONSENT - ELECTRO CONVULSIVE THERAPY
PART 1
INFORMATION TO CONSIDER BEFORE SIGNING

The treatment is recommended where the alternative forms of treatment have either not had the desired result or would work too slowly to be effective in a particular case.

The treatment will take the following form:

- (a) You will be given a brief general anaesthetic. This involves giving a drug to relax the muscles. The anaesthetist will generally give the anaesthetic by means of intravenous injection.
- (b) While you are anaesthetised, another medical practitioner will use medical apparatus designed to pass a modified electrical current for a few seconds through your brain, with the intention of affecting those parts concerned with emotion and thought.
- (c) While the current is passing, the anaesthetic will prevent you from feeling anything and also your body from moving more than slightly.
- (d) Treatment may be given 2 or 3 times a week.
- (e) A course of treatment will generally involve up to 12 treatments but, on some occasions, more treatments will be required. Any queries you have in relation to the number of treatments you may need can be raised with your doctor.

Possible benefits of treatment:

Benefits depend upon the symptoms of the conditions for which treatment is given. Relief may be obtained from symptoms of depression, agitation and insomnia.

Possible alternative treatments:

Other treatments may also be suitable for your condition. Any queries you have in relation to these can be discussed with your doctor.

A written explanation of the alternative treatments available in relation to your condition is attached.

Possible complications of treatment:

Some patients notice a difficulty with their memory for recent events which almost invariably clears up within a month of receiving the last treatment. Some patients experience a headache or a brief period of confusion, or both, on awakening after the anaesthetic. Otherwise, because the treatment and anaesthetic are very brief and present no significant stress to the body, serious complications are uncommon. All general anaesthetics carry some risk.

Consent for treatment:

This treatment cannot be carried out without your consent (see Part 2 below), unless you are an involuntary patient at the hospital. If you are an involuntary patient, the treatment can be only carried out without your consent after a full hearing before the Mental Health Review Tribunal.

Before giving this consent you may ask your doctor any questions relating to the techniques or procedures to be followed. You may also withdraw your consent and discontinue this treatment AT ANY TIME.

Legal advice:

You also have the right to get legal advice and medical advice before you give your consent.

DISCLOSURE OF FINANCIAL RELATIONSHIP
Item A

To be completed by the person proposing the administration of the treatment.

- (a) I declare that there is no financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

OR

- (b) I declare that the following is a full disclosure of the financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

Signature _____

Name _____

Item B

To be completed by the medical practitioner who proposes to administer the treatment (unless that medical practitioner is also the person who completed Item A, in which case this item need not be completed).

(a) I declare that there is no financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

OR

(b) I declare that the following is a full disclosure of the financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

Signature _____

Name _____

**PART 2
CONSENT TO ELECTRO CONVULSIVE THERAPY**

I, _____
(Name in full)

consent to being treated with a course of electro convulsive therapy.

I *acknowledge* that I have read/have had read to me Part 1 of this form, and that I understand the information it contains.

I *understand* that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

Signature _____ Date _____

**PART 3
CONSENT TO ELECTRO CONVULSIVE THERAPY (INVOLUNTARY PATIENTS)**

I, _____
(Name in full)

consent to being treated with electro convulsive therapy.

I *acknowledge* that I have read/have had read to me Part 1 of this form, and that I understand the information it contains.

I *understand* that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

I *understand* that my consent will be reviewed by the Mental Health Review Tribunal.

Signature _____ Date _____

CERTIFICATION OF WITNESS

I certify that all matters dealt with in this Form have been orally explained to the person in respect of whom treatment is proposed and have been so explained in a language with which that person is familiar.

Signature _____ Date _____

**NOTIFICATION OF APPLICATION TO DETERMINE VALIDITY OF
CONSENT TO ELECTRO CONVULSIVE THERAPY- PERSONS OTHER
THAN INVOLUNTARY PATIENTS**

Dear _____

It is my opinion as Medical Superintendent of

(name of the hospital)

that it is desirable and in the best interests of

(full name of person the subject of the application)

for him/her to undergo a course of electro convulsive therapy. He or she has consented.

However, I am unsure whether he or she is capable of giving informed consent to the treatment.

In such cases I am required by law to notify you in writing that an application is being made to the Mental Health Review Tribunal to determine whether he or she is capable of giving informed consent and has given that consent.

He or she has consented to me giving you this notice.

If you wish to discuss this matter further please contact:

_____ on _____

(name)

(telephone number)

Yours faithfully,

(Medical Superintendent)

(Date)

NOTIFICATION OF APPLICATION TO ADMINISTER ELECTRO CONVULSIVE THERAPY – INVOLUNTARY PATIENTS

Dear _____

It is my opinion as Medical Superintendent of

(name of hospital)

that it is desirable and in the best interests of

(patient's full name)

for him/her to undergo a course of electro convulsive therapy.

The patient:

- has consented to the treatment.
- is incapable of giving consent to the treatment.
- is capable of giving consent to the treatment but has refused to do so.
- is capable of giving consent to the treatment but has neither refused nor consented.

(Tick one box only)

In such cases I am required by law to notify you in writing that an application is being made to the Mental Health Review Tribunal to determine:

- (a) whether the patient is capable of giving informed consent to the administration of the treatment and has given that consent; and
- (b) if the patient is incapable of giving informed consent or has not consented – whether the treatment is necessary or desirable for the safety or welfare of the patient.

If you wish to discuss this matter further please contact:

_____ on _____
(name) (telephone number)

Yours faithfully,

(Medical Superintendent)

(Date)

FORM 15 IS THE REGISTER OF ELECTRO CONVULSIVE THERAPY TREATMENTS

This form is unchanged from that in earlier Regulations (except as to the form number). There are remaining stocks of the Registers and it is intended to continue to use those stocks.

ECT Registers can be obtained from the Centre for Mental Health, NSW Health Department, Locked Bag 961, North Sydney 2059 (telephone 9391-9308).

NOTIFICATION TO RELATIVE

Dear _____

It is my opinion as Medical Superintendent of

(Name of Hospital)

that it is desirable and in the best interests of

(Patient's full name)

who is involuntarily detained in the hospital in accordance with the *Mental Health Act 1990*, to undergo a surgical operation or special medical treatment for

(lay description of condition)

This operation or treatment is called _____
(medical name)

To perform the surgery, or carry out the treatment, I am required by law to obtain the patient's consent.

However the patient is:

- incapable of giving that consent
- capable of giving that consent but has refused to do so
- capable of giving that consent but has neither refused nor consented

(Tick one box only)

In such cases I am required by law to notify you in writing that it is my intention to obtain consent on the patient's behalf from the Mental Health Review Tribunal.

If you wish to discuss this matter further please contact

_____ on _____
(Name) (Telephone number)

Yours faithfully,

(Medical superintendent)

(Date)

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 17

(Cl.35)

MENTAL HEALTH ACT 1990
Section 278 (1)

SUMMONS
Mental Health Review Tribunal

To: _____

The Mental Health Tribunal will be hearing matters in relation to

(name of patient)

The hearing will take place on _____ on _____
(time) (date)

at _____
(address)

You are required:

- * to attend the hearing as a witness
- * to attend the hearing and produce the following documents:

(* delete if inapplicable)

You are entitled to receive reasonable costs, including any loss of earnings incurred through compliance with this summons.

Should you fail or refuse to comply with this summons, properly served, you may be guilty of an offence under the Mental Health Act 1990.

If you are required to attend the hearing only to produce documents, it is sufficient compliance with this summons if those documents are delivered to

at _____

on or before _____

Signature _____

President/Deputy President
Mental Health Review Tribunal

FORM 18

This is the oath of office to be taken by persons appointed as Assessors to assist the Supreme Court in any matters coming before it under the Mental Health Act.

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 19

(Cl.40)

MENTAL HEALTH ACT 1990
Section 302 (2) (m)

PSYCHIATRIC ADMISSIONS

Advice to Mental Health Review Tribunal

INSTRUCTIONS

Follow the instructions set out below to fill in this form. Tick the boxes provided or write in the information required.

For patients reclassified from informal patients to involuntary patients

Fill out sections A, B and D *only* of this form.

For other patients (not being forensic patients or informal patients) detained in the hospital

Fill out sections A, C and D *only* of this form.

When to fill out the form

The form should be filled out as soon as practicable after the occurrence of the first of any of the following events in relation to a patient or detained person:

- conclusion of Magistrate's inquiry in respect of a patient
- discharge of a patient
- a temporary patient or continued treatment patient being reclassified as an informal patient
- a person ceasing to be detained in the hospital

Where to send the form

This form is to be sent not later than 21 days after the first event occurs to The Registrar of the Mental Health Review Tribunal.

Should you have any questions about the form contact the Registrar or Deputy Registrar of the Tribunal by telephone.

SECTION A. INVOLUNTARY

To be completed for all **involuntary** patients.

Q1. Hospital_____

Q2. Medical Record Number_____

Q3. Date of Birth_____

Q4. Sex_____

Q5. Country of Birth_____

Q6. Interpreter required Yes [] No [] Language_____

SECTION B. RECLASSIFICATION

To be completed for all Patients **reclassified** from informal to involuntary and for all patients presenting voluntarily but who are scheduled at the admission office.

Q7. If the patient was reclassified to involuntary, when was this done?

SECTION C. INITIAL ADMISSION

To be completed for patients taken to hospitals only.

Q8. Date taken to hospital _____

Q9. **Method of referral** (*Tick one box*)

- | | |
|---|--------------|
| <input type="checkbox"/> Certificate of medical practitioner | sec.21 |
| <input type="checkbox"/> Request by relative/friend | sec.23 |
| <input type="checkbox"/> Apprehension by police | sec.24 |
| <input type="checkbox"/> Order under sec. 33 Mental Health
(Criminal Procedure Act) 1990 | sec.25 |
| <input type="checkbox"/> Welfare officer or welfare officer with police assistance | sec.26 |
| <input type="checkbox"/> Authorised medical practitioner's certificate | secs. 21, 27 |
| <input type="checkbox"/> Breach of Community Treatment Order | sec.142 |

Q10. After examination was the patient admitted?

Yes No

Q11. On admission was the patient classified as

- Informal
- Involuntary, mentally ill
- Involuntary, mentally disordered

Q12. Was the patient discharged by hospital before Magistrate's inquiry?

Yes No

If yes, when _____

SECTION D. INVOLUNTARY

To be completed for all **involuntary** patients.

Q13. Was the patient presented to a Magistrate?

Yes No

Q14. If yes to Q13, what was the date of the inquiry _____
(*If inquiry completed, proceed with Q16.*)

Q15. Was the case adjourned?

Yes No If yes, until when? _____

(*Note: If the patient was then presented again at a resumed hearing, proceed with Q16*)

Q16. At the first or resumed hearing, what was the Magistrate's decision?

- Discharge
 - Defer discharge. For how long _____
 - Classify patient as Temporary Patient
Until when? _____
 - Make a Community Treatment Order
 - Make a Community Counselling Order
 - Any other order (please specify)
- _____

ORDER OR DIRECTION OF MAGISTRATE - INQUIRY RELATING TO MENTALLY ILL PERSON

Hospital _____

Address _____

Date _____

(Complete Part 1 or Part 2 only)

Part 1 – Order or Direction

I have today ordered or directed that _____
(patient's name)

(who was brought before me under section 38 of the *Mental Health Act 1990*):

- must be discharged from hospital
- must be discharged from hospital into the care of

(name)

- must be detained as a temporary patient until no later than _____
(date)
for further observation or treatment, or both

- must be made subject to a community treatment order
- must be made subject to a community counselling order

(Tick one box only)

The reasons for my order or direction (as required by section 53 of the Act) are annexed to this form.

(OR)

Part 2 Order for adjournment

I have today ordered the adjournment of the inquiry in relation to _____

_____ (who was brought before me under section 38 of the
Mental Health Act 1990) for a period of _____ days.

The reasons for my order (as required by section 53 of the Act) are annexed to this form.

Signature of Magistrate _____

Name of Magistrate _____

MENTAL HEALTH ACT 1990
Section 12(1)

PERSONAL APPLICATION FOR INFORMAL ADMISSION TO HOSPITAL

I, _____ request admission to
(Name in full)

_____, for treatment as an Informal Patient.
(Name of Hospital)

Intending patient's signature: _____

Date: ___/___/___

VERIFICATION

The above application was made apparently freely and voluntarily, in my presence.

Signature of Witness: _____

Date: ___/___/___

or, in the case of a person who needs the assistance of an interpreter, -

I have interpreted the content of this form to the intending patient, who has signed above. The above application was made apparently freely and voluntarily, in my presence.

Signature of Interpreter: _____

Date: ___/___/___

MENTAL HEALTH ACT 1990
Section 12(2)

**APPLICATION FOR INFORMAL ADMISSION TO HOSPITAL
OF A PERSON SUBJECT TO A GUARDIANSHIP ORDER
UNDER THE GUARDIANSHIP ACT 1987**

I, _____
(Name of Guardian in full)

being the appointed Guardian under section 14 of the Guardianship Act 1987 of

(Name of intended patient in full)

request that he/she be admitted to _____,
(Name of Hospital),
for treatment as an Informal Patient.

This application is made:

- * with the approval of the Guardianship Tribunal as required by section 12(2) of the *Mental Health Act 1990* (copy of approval to be provided)

OR

- * subject to the approval of the Guardianship Tribunal,
which was/will be sought on _____.
(Date application was made or is to be made)

* delete whichever is inapplicable

Guardian's signature: _____

Date: ___/___/___

I have interpreted the content of this form to the Guardian.

Signature of Interpreter: _____

Date: ___/___/___

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 19(1)

APPLICATION FOR REVIEW OF DECISION OF MEDICAL OFFICER

To, The Medical Superintendent,

(Name of Hospital)

I, _____ request review of the decision:
(Name in full)

* not admit me as an informal patient

* not to admit _____
(Name in full)

for whom I am the appointed Guardian under section 14 of the
Guardianship Act 1987

* to discharge me as an informal patient

* to discharge _____
(Name in full)

for whom I am the appointed Guardian under section 14 of the
Guardianship Act 1987

** delete whichever is inapplicable*

Signature: _____

Date: ___/___/___

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990

Section 55

YOUR RIGHTS AFTER THE MAGISTRATE'S INQUIRY

On _____ you went to the Magistrate's Inquiry at
(date)

_____ and the Magistrate ordered that -
(Name of Hospital)

- * You be detained as a Temporary Patient for further observation and/or treatment until _____.
(date)
- * You be discharged subject to a Community Treatment Order or Community Counselling Order.
- * Your estate be managed, on your behalf, by the Protective Commissioner.
- * *delete where inapplicable*

YOU HAVE THE FOLLOWING RIGHTS OF APPEAL AGAINST THESE ORDERS

If you are ordered to remain in Hospital as a Temporary Patient:

- You may ask the Medical Superintendent to discharge you.
- You may ask the Medical Superintendent to reclassify you as an Informal (voluntary) Patient. The Medical Superintendent would only do this if satisfied that you would benefit from treatment as an Informal Patient.
- A relative or friend may apply in writing asking the Medical Superintendent to discharge you. The application must satisfy the Medical Superintendent that you will be properly taken care of and be prevented from causing harm to yourself or other people.
- If the Medical Superintendent refuses an application for your discharge, or fails to decide within three working days, you or your relative or friend may appeal to the Mental Health Review Tribunal.
- If the Mental Health Review Tribunal disallows your appeal, you may further appeal to the Supreme Court. This is expensive and may take some time. Some free legal advice may be available from the Mental Health Advocacy Service.

(Reverse of CMH 4)

- Any person may take a case to the Supreme Court to seek the discharge of a person, where there is evidence the person is not a mentally ill or mentally disordered person or where other care of a less restrictive kind is appropriate and reasonably available.

If you are discharged on a Community Treatment Order or Community Counselling Order:

- You may appeal to the Mental Health Review Tribunal.

If an order is made that your estate be managed by the Protective Commissioner:

- You may appeal to the Supreme Court. To do this you will need legal advice. Some free legal advice may be available from the Mental Health Advocacy Service.
- Once you have ceased to be a patient in the hospital, you may appeal to the Mental Health Review Tribunal.

WHILST YOU ARE AWAITING CONSIDERATION OF AN APPEAL YOU MUST COMPLY WITH ALL LEGAL ORDERS WHICH HAVE BEEN MADE.

These telephone numbers may be of some assistance to you:

- Mental Health Advocacy Service 9745-4277
- Mental Health Review Tribunal 9816-5955
- Office of the Protective Commissioner 9265-3131

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 65(3)

NOTICE OF DISCHARGE OF PERSON UNDER GUARDIANSHIP

(Name of Hospital)

(Address of Hospital)

To _____
(Full name of guardian)

Notice is hereby given that _____,
(Full name of patient)

an Informal Patient at _____,
(Name of Hospital)

will be discharged from this facility on _____.
(Date)

Signature: _____
(Medical Superintendent)

Name: _____

Date: ___/___/___

MENTAL HEALTH ACT 1990
Section 148(5)

APPLICATION FOR VARIATION/REVOCAION OF ORDER

To: The Registrar
Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111

On _____, * a Community Treatment Order
(Date) * a Community Counselling Order

was made in relation to _____,
(Patient's full name)

by * a Magistrate
* the Mental Health Review Tribunal.

I, _____, being
(Full name of applicant)

- * the person for whom the order was made
- * the psychiatric case manager implementing the order
- * an authorised applicant under Schedule 1 of the Act,

do hereby apply for the order to be * revoked
* varied, as follows

** delete where inapplicable*

Applicants signature _____

Applicant's contact information _____

(address and telephone number)

Date: ___/___/___

MENTAL HEALTH ACT 1990
Section 24

**REQUEST BY MEMBER OF THE NSW POLICE SERVICE
FOR ADMISSION OF AN ALLEGED MENTALLY DISTURBED
PERSON INTO A PSYCHIATRIC HOSPITAL**

I, the undersigned, _____, a Police Officer
(Name in full)

at present attached to _____ Police Station,

inform you, the Medical Superintendent of _____

Psychiatric Hospital that it appears to me that _____,
(Name in full, if available)

is mentally disturbed, and further that I have reason to believe when apprehended

he/she: * was committing or had recently committed
an offence, and would benefit from being
dealt with under the Mental Health Act,
rather than otherwise in accordance with
law.

 * has recently attempted to kill himself/herself
or that it is probable he/she will attempt to
kill himself/herself or attempt to cause
serious bodily harm to himself/herself.

** delete where inapplicable*

Further details of the circumstances leading to this request for admission appear
over page.

Dated: ___ / ___ / _____

At: _____

Signature: _____

Rank: _____

Address: _____

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 26

**REQUEST BY A WELFARE OFFICER FOR THE
ADMISSION OF PERSON INTO A PSYCHIATRIC HOSPITAL**

I, the undersigned, _____, a Welfare Officer
(Name in full)

appointed under the *Mental Health Act 1990*, inform you, the Medical

Superintendent of _____ Psychiatric Hospital

that I believe _____,
(Name in full, if available)

to be * a mentally ill person
 * a mentally disordered person.

** delete where inapplicable*

Further details of the relevant circumstances leading to this request for admission appear over page.

Dated: ___/___/___

At: _____

Signature: _____

Address: _____

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 67

APPLICATION FOR DISCHARGE FROM HOSPITAL

To, The Medical Superintendent

I, _____, being a Temporary
(Name in full)

or Continued Treatment Patient at _____,
(Name of Hospital)

request to be discharged from the Hospital.

Date: ___/___/___

Signature: _____

Address: _____

INFORMATION

This application should be given to the Medical Superintendent or to another member of the Hospital's medical staff.

If the Medical Superintendent refuses your application or fails to make a decision within three working days, you, or a relative or friend, may appeal to the Mental Health Review Tribunal.

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 68

**APPLICATION FROM RELATIVE OR FRIEND
FOR PATIENTS DISCHARGE FROM HOSPITAL**

To, The Medical Superintendent

I, _____, being a relative or
(Full name of Applicant)

friend of _____, who is a
(Full name of patient)

Temporary or Continued Treatment Patient at _____,
(Name of Hospital)

request that he/she be discharged from the Hospital.

Date: ___/___/___

Signature: _____

Address: _____

INFORMATION

This application should be given to the Medical Superintendent or to another member of the Hospitals medical staff.

If the Medical Superintendent refuses your application or fails to make a decision within three working days, you, the patient or another person appointed by the patient, may appeal to the Mental Health Review Tribunal.

MENTAL HEALTH ACT 1990
Section 128

BREACH OF COMMUNITY COUNSELLING ORDER
NOTICE TO PATIENT

(Name of Health Care Agency)

(Address)

To _____
(Patient's name)

(Address)

Notice is hereby given that as a result of:

1. Your refusal to comply with your community counselling order;
2. Your further refusal to comply after intervention of your psychiatric case manager as required by section 127 of the Mental Health Act 1990; and
3. You being informed that such further refusal will result in an order to attend the Health Care Agency,

YOU ARE NOW REQUIRED under section 128 of the Mental Health Act 1990 to attend the Health Care Agency at the address given above for counselling/assessment/administration of medication *.

* (delete where inapplicable)

Under section 128 of the Mental Health Act 1990, I am required to warn you that the assistance of the NSW Police Service may be obtained to ensure your attendance as set out above.

Signature: _____

Name: _____
(Director of Health Care Agency)

Date: ____/____/____

MENTAL HEALTH ACT 1990
Section 138

BREACH OF COMMUNITY TREATMENT ORDER
NOTICE TO PATIENT

(Name of Health Care Agency)

(Address)

To _____
(Patient's name)

(Address)

Notice is hereby given that as a result of:

1. Your refusal to comply with your community treatment order (copy attached);
2. Your further refusal to comply after intervention of your psychiatric case manager as required by section 137 of the Mental Health Act 1990; and
3. You being informed that such further refusal will result in an order to attend the Health Care Agency,

YOU ARE NOW REQUIRED under section 138 of the Mental Health Act 1990 to attend the Health Care Agency at the address given above for counselling/ assessment/administration of medication *.

* (delete where inapplicable)

Under section 138 of the Mental Health Act 1990, I am required to warn you that the assistance of the NSW Police Service may be obtained to ensure your attendance as set out above.

Signature: _____

Name: _____
(Director of Health Care Agency)

Date: ____/____/____

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 78

**TRANSFER BETWEEN HOSPITALS
OF INVOLUNTARY PATIENT**

Name of patient being transferred _____

from _____ Hospital

to _____ Hospital.

The abovementioned transfer in terms of section 78 of the Mental Health Act 1990
has been arranged, with your concurrence, to take effect on ____/____/____.

- * As required by section 78(3), I have done all such things as are reasonably practicable to give notice of this transfer, and the reasons therefore, to the patient's nearest relative/a relative nominated by the patient/a person said by the patient to be a close friend.
- * As this transfer arises from circumstances constituting, in my opinion, an emergency, I will, after the patient is transferred, do all such things as are reasonably practicable to give an emergency notice of this transfer, and the reasons therefore, to the patient's nearest relative/a relative nominated by the patient/a person said by the patient to be a close friend.

** delete whichever is inapplicable*

Signature of Medical Superintendent: _____

Name: _____

To, the Medical Superintendent,

_____ Hospital

Mental Health Act 1990

Section 286

U/R No.

Unit Record No

Ward

Family Name

Given Names

D.O.B. Sex

Alias.....

TRANSFER OF AN INVOLUNTARY PATIENT TO AN INTERSTATE MENTAL HEALTH FACILITY

TO BE COMPLETED BY *MEDICAL SUPERINTENDENT/DELEGATE:

I,
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) *Medical Superintendent/ Delegate

ORDER THAT
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of involuntary patient

an involuntary patient at
gazetted hospital/premises pursuant to section 208 Mental Health Act 1990 (NSW)

be transferred from the abovenamed hospital to
Name and address of admitting interstate mental health facility**

on: the day of 20.....

I am satisfied that:

the patient will benefit from the transfer; **and/or**

the transfer is necessary for the patient's treatment;

and

the patient could continue to be detained in an approved mental health service; **and**

the interstate authority for the interstate mental health facility has agreed in writing to the transfer (attached).

(tick whichever applies)

signed dated/...../.....

*Medical Superintendent/ Delegate

CMH 14

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON**

(Secs. 21, 22)

MENTAL HEALTH ACT 1990

PART 1

1, (Medical Practitioner/accredited person)
(name in full - use block letters)

of certify that

on 19 immediately before or shortly before completing

this certificate, at
(state place where examination/observation took place)

I personally examined/personally observed
(name of person in full)

for a period of
(state length of examination/observation)

I certify the following matters:

1. I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness/or a mentally disordered person and that there are reasonable grounds for believing the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

*(a) in the case of a mentally ill person:

- (i) for the person's own protection from serious harm; or
- (ii) for the protection of others from serious harm; or

*(b) in the case of a mentally disordered person:

- (i) for the person's own protection from serious physical harm; or
- (ii) for the protection of others from serious physical harm.

2. I have satisfied myself, by such inquiry as is reasonable having regard to the circumstances of the case, that the person's involuntary admission to and detention in a hospital are necessary and that no other care of a less restrictive kind is appropriate and reasonably available to the person.

3. Incidents and/or abnormalities of behaviour and conduct (a) observed by myself and (b) communicated to me by others (state name, relationship and address of each informant) are:

(a)

.....

.....

.....

** delete whichever is not applicable*

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON – continued**

(b)

.....

.....

.....

4. The general medical and/or surgical condition of the person is as follows:

.....

.....

.....

5. The following medication (if any) has been administered for purposes of psychiatric therapy or sedation:

.....

.....

.....

6. I am not a near relative of the person.

7. I have/do not have a pecuniary interest, directly or indirectly, in an authorised hospital.
I have/do not have a near relative/partner/assistant who has such an interest.
Particulars of the interest are as follows:

.....

.....

.....

Made and signed this day of 20.....

Signature:

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON – continued**

PART 2

If the assistance of a Police Officer is required, this part of the Form should be completed.

YOU SHOULD NOT REQUEST THIS ASSISTANCE UNLESS IT IS NECESSARY AND THERE ARE NO OTHER MEANS OF TAKING THE PERSON TO HOSPITAL REASONABLY AVAILABLE.

I am of the opinion, in relation to
(name of person in full)

- (a) that the condition of the person is such that the assistance of a Police Officer is required in order to take the person to a hospital; and
- (b) that no other means of taking the person to a hospital are reasonably available.

Made and signed this day of 20

Signature:

NOTES:

1. Chapter 3 of the Mental Health Act 1990 states:

**8. Criteria for involuntary admission etc. as mentally ill person or mentally
disordered person**

A person is a mentally ill person or a mentally disordered person for the purpose of:

- (a) the involuntary admission of the person to a hospital or the detention of the person in a hospital under this Act; or
- (b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a hospital, if, and only if, the person satisfies the relevant criteria set out in this Chapter.

9. Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious harm; or
- (b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

10. Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious physical harm; or
- (b) for the protection of others from serious physical harm.

SCHEDULE 2 - MEDICAL CERTIFICATE AS TO EXAMINATION OR OBSERVATION OF PERSON - continued

11. Certain words or conduct may not indicate mental illness or disorder

(1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:

- (a) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief;
- (b) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief;
- (c) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy;
- (d) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation;
- (e) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity
- (f) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;
- (g) that the person engages in or has engaged in sexual promiscuity;
- (h) that the person engages in or has engaged in immoral conduct;
- (i) that the person engages in or has engaged in illegal conduct;
- (j) that the person has developmental disability of mind;
- (k) that the person takes or has taken alcohol or any other drug;
- (l) that the person engages in or has engaged in anti-social behaviour.

(2) Nothing in this Chapter prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

2. In addition to matters ascertained as a consequence of personally examining or observing the person, account may be taken of other matters not so ascertained where those matters:

- (a) arise from a previous personal examination of the person; or
- (b) are communicated by a reasonably credible informant.

3. In the Mental Health Act 1990 "mental illness" is defined as follows:

mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

- (a) delusions;
- (b) hallucinations;
- (c) serious disorder of thought form;
- (d) a severe disturbance of mood;
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

4. In the Mental Health Act 1990 "near relative" is defined as follows:

near relative, in relation to a **person**, means a parent, brother, sister or child or the spouse of the person and such other person or persons as may be prescribed as a near relative of the person.

5. For admission purposes, this certificate is valid only for a period of 5 days, in the case of a person who is a mentally ill person, or 1 day, in the case of a person who is a mentally disordered person, after the date on which the certificate is given.

MENTAL HEALTH ACT 1990
SCHEDULE 3 – MEDICAL CERTIFICATE AS TO EXAMINATION OF INMATE

(sections 97 and 98)

I, _____ (Psychiatrist, Medical Practitioner)
(Name in full – use block letters) *(delete one)*

of the Corrections Health Service do hereby certify that on the _____ day of

_____ 20____, at _____
(state name of correctional centre where examination took place)

separately from any other medical practitioner, I personally examined

(Name of inmate in full)

_____ and I am of the opinion
(MIN) *(Date of birth)*

that he/she is *(delete one)* * a mentally ill person within the meaning of the Act
* suffering from a mental condition for which
treatment is available in a hospital.

I have formed this opinion on the following grounds:

(1) Facts indicating mental illness/mental condition observed by myself

(2) Other relevant information (if any) communicated to me by others (state name and address of each informant)

Made and signed this _____ day of _____ 20____.

Signature _____

Mental Health Review Tribunal Material

- 1 Supporting documentation requested by the Tribunal
- 2 Application for hearing
- 3 Sample application for Community Order
- 4 Sample treatment Plan
- 5 Checklists for those appearing before the Tribunal
- 6 Sample reports
 - Application for temporary patient order
 - Application for CTO

SUPPORTING DOCUMENTATION REQUESTED BY THE TRIBUNAL

<i>Order</i>	<i>Documentation Required</i>
Extension of Temporary Patient Order (TPO)	<ul style="list-style-type: none"> • Copy of current Temporary Patient Order • Report from treating doctor • Report from hospital social worker if possible • Report from community case manager if relevant
Community Treatment Order (CTO)	<ul style="list-style-type: none"> • Copy of current order – TPO or CTO • Application for Community Order • Report from applicant on reason for order • Treatment Plan • Report on efficacy of previous Treatment Plan if patient is on a community order which is expiring
Community Counselling Order (CCO)	<ul style="list-style-type: none"> • Application for Community Order • Report from applicant on reason for order • Treatment Plan • Report on efficacy of any previous Treatment Plan
Consent for ECT	<ul style="list-style-type: none"> • Information and Consent: Form 12 if appropriate • Certificates from 2 medical practitioners of whom at least one should be a psychiatrist, that ECT is a reasonable, and proper treatment for the patient and is necessary or desirable to be administered to the patient.
Consent for surgery where no relatives or relatives refuse to consent in writing (for details of procedure in other circumstances check with Tribunal)	<ul style="list-style-type: none"> • Application from the medical superintendent of the hospital • Written report from medical superintendent about why the patient cannot give or refuses, or is unable to give informed consent • Written report from a medical practitioner, explaining the reasons for, benefits of and contra-indications of surgery • Evidence of attempt to, or giving of, notice to relatives and get their views: Form 16.
Consent for special medical treatment	<ul style="list-style-type: none"> • Refer Mental Health Review Tribunal
Protected Estates application	<ul style="list-style-type: none"> • Report from treating doctor and/or social worker regarding the patient's capacity to manage his/her own affairs, stating the reasons for coming to this view.
Continued Treatment Order	<ul style="list-style-type: none"> • Copy of current order • Report from treating doctor • Report from hospital social worker
<i>Appeal</i>	<i>Documentation Required</i>
Against refusal to discharge	<ul style="list-style-type: none"> • Report from medical superintendent (or nominee) about refusal to discharge: Form MHRT 6A/91
Against Protected Estates Order	<ul style="list-style-type: none"> • Report from health professional, i.e. social worker, medical practitioner, etc. regarding your appeal • Report from Estate Manager
To vary or revoke Community Order	<ul style="list-style-type: none"> • Report from case manager and/or psychiatrist

APPLICATION FOR HEARING

FOR FACSIMILE TRANSMISSION ONLY

APPLICATION FOR HEARING BY MENTAL HEALTH REVIEW TRIBUNAL

FROM: HOSPITAL/HEALTH CENTRE:
 PROPOSED VENUE:
 HOSPITAL/HEALTH CENTRE CONTACT PERSON:
 Tel: Fax:

TO: SENIOR TRIBUNAL CLERK, MHRT, Tel: (02) 9816 5955 Fax: (02) 9817 4543

CLIENT DETAILS	CLIENT 1	CLIENT 2
Surname		
Given Names		
Date of Birth		
Country of Birth		
Hospital (<i>not Health Centre</i>) Medical Record Number		
Private Address (for clients currently living in the community)		
Nature of Current Order		
Expiry Date of Current Order (<i>if applicable</i>)		

REASON(S) FOR REQUESTING TRIBUNAL HEARING

(please tick box)

Patient 1

Patient 2

ORDERS:

- | | | |
|---------------------------------------|--------------------------|--------------------------|
| Extend temporary order | <input type="checkbox"/> | <input type="checkbox"/> |
| * Community treatment order | <input type="checkbox"/> | <input type="checkbox"/> |
| * Community counselling order | <input type="checkbox"/> | <input type="checkbox"/> |
| Consent for ECT | <input type="checkbox"/> | <input type="checkbox"/> |
| Consent for surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Consent for special medical treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Protected estates application | <input type="checkbox"/> | <input type="checkbox"/> |
| Continued treatment order | <input type="checkbox"/> | <input type="checkbox"/> |

APPEALS:

- | | | |
|--|--------------------------|--------------------------|
| Against refusal to discharge
(after magistrate's order) | <input type="checkbox"/> | <input type="checkbox"/> |
| Against Protected Estates order | <input type="checkbox"/> | <input type="checkbox"/> |
| Against CTO made by magistrate | <input type="checkbox"/> | <input type="checkbox"/> |

*PLEASE PROVIDE AT LEAST TWO WEEKS' NOTICE FOR CTO OR CCO APPLICATIONS.

1. Please ensure that copies of all relevant reports and treatment plans are provided to the Tribunal prior to the hearing.
2. If seeking an extension of an order, please allow sufficient time prior to the expiry date to enable the patient to seek legal advice if required and (for community orders) to enable the Tribunal officially to notify the patient concerning hearing arrangements and his or her rights under the Mental Health Act 1990.

5. CLINICAL, MANAGEMENT, REHABILITATION, PLANNING ETC

Brief history of patient or client and diagnosis

Effectiveness of previous treatment in ameliorating condition, effecting recovery, or preventing deterioration; History of non-compliance, subsequent relapse, and consequences; Effect of any current CTO:

Duration of order requested (maximum 6 months)

Advantages of community order for safe, effective, and least restrictive possible care

Rationale for treatment plan

Attitude of patient/client, and relations/friends (if applicable) to application

Evidence from psychiatrist of likely relapse, so that client will become a “mentally ill person” within three months (on application for CCO) if CCO not made

Attempts by health care agency to maintain contact and gain consent to treatment (on application for CCO)

Applicant’s signature: Date:

Client's given name(s):

Surname:

Client's address:

.....

Health care agency:

.....

Director:

Address of health care agency:

.....

Case Manager:

Treating Psychiatrist:

Order sought: *please tick box*

CCO

FIRST CTO

SECOND OR SEBSEQUENT CTO

1. The TREATMENT PLAN should set out the following particulars if relevant:

1.1 Any obligations on the client to make contact with other person, eg treating psychiatrist, case manager:

.....

• person(s) to be contacted

.....

• contact times (eg weekly, monthly, etc)

.....

• place of contact

.....

• medium of contact (eg by telephone, or by personal attendance at a particular place, etc)

.....

.....

This information should be presented on Community Health Centre letterhead, or prepared on this form and accompanied by a covering letter on agency letterhead.

Name of Person affected by order:

1.2 MEDICATION: who is to prescribe and administer; how, when and where:

.....
.....
.....
.....
.....

1.3 Requirements as to attendance at the health care agency, and/or other rehabilitation services; and frequency of attendance.

.....
.....
.....
.....
.....

1.4 Other services to be provided to the patient (e.g. support services, educational facilities, family counselling and education, etc.)

.....
.....
.....
.....

2. To the extent that they are not subsumed under the above headings, the treatment plan should set out the duties and undertakings of both parties (client, health care agency).

.....
.....
.....
.....
.....

Signed:
(Director)

Signed:
(Case Manager)

Checklists for those attending Tribunal Hearings

These have been prepared by the MHRT.

Consultant psychiatrists and psychiatric registrars

- clinical history
- current mental condition
- treatment provided – current medication and dosage
- proposed and alternative treatments
- other therapy provided
- person's responses to treatment, therapy and treatment plan
- outlook for future management and rehabilitation
- past compliance with treatments
- consequences of compliance/non-compliance

Case managers and social workers

- social history
- treatment plan
- current accommodation and future options
- rehabilitation programs planned or undertaken
- additional activities
- practicalities of day to day management
- patient's views about treatment plan
- patient's support network
- patient's financial management skills
- views of relatives/friends
- opinion on whether this is the least restrictive alternative
- patient's progress under order.

Nurses

- current mental condition
- behaviour on the ward, including sleeping, eating
- relationships with visitors and others on the ward
- response to in ward/out of ward programs
- response to medication.

Consumers

- views about proposed plan, hospitalisation or treatment
- information about available support
- views on medication
- views on leaving hospital
- views on ability to manage mental illness.

Family members and friends

- general experience with the patient in the past/at home
- ability to cope if the patient leaves or stays in hospital
- views on the treatment, treatment plan or hospitalisation
- concerns about the proposed plan, hospitalisation or treatment.

Sample Report

Application for Temporary Patient Order (or Extension)

Mr A is a 42 year old man with a diagnosis of Schizophrenia. He lives in his own Housing Department accommodation. He has had 4 previous admissions to this hospital and is a registered client of the community mental health service.

Mr A was brought in to hospital on a Schedule 2. The community team reports a six week deterioration in his mental state. Mr A's father recently died and since this time Mr A reports an increase in auditory hallucinations and persecutory ideas revolving around fears that he is being poisoned. Subsequently Mr A has stopped eating with marked deterioration in his physical health. At the time of admission Mr A was refusing any treatment and would not consider admission to hospital.

At present Mr A is being treated with the following medications:

.....

This medication has produced a slight improvement in his mental state. However, Mr A has continued to report hearing voices telling him to stop eating, and remains reluctant to eat any of the food provided for him. In the past it has taken up to two months to see a significant improvement in his mental state.

It is evident then that Mr A is currently a mentally ill person as defined by the Mental Health Act with the presence of auditory hallucinations and delusions, and the risk of serious harm he presents to himself.

I therefore request that Mr A be detained as a Temporary Patient for a period of up to four weeks.

Signed: _____

Sample Report for CTO

1. THIS IS AN APPLICATION FOR A: *please tick box*

- CCO
- CTO FIRST APPLICATION
- CTO SECOND OR SUBSEQUENT APPLICATION

2. ATTACHED REPORTS:

- (A) CCO (s122)
 - 1. Attach section 136 report on efficacy of any recently expired CTO
 - 2. Attach section 126 report on efficacy of any previous CCO
- (B) CTO (s134)
 - 1. Attach section 136 reports on efficacy of any current CTO
 - 2. Attach section 126 report on efficacy of any recently CCO

3. APPLICANT DETAILS:

Agency Name:

Address:

4. CLIENT DETAILS:

Hospital or residential address:

Given name(s): Ms B.....

Surname:

Date of birth:

Medical Record Number if hospital patient:

5. CLINICAL, MANAGEMENT, REHABILITATION, PLANNING, ETC.

Brief history of client and diagnosis:

Ms B is a 35 year old woman with a diagnosis of Schizophrenia. She currently lives alone in Housing Department accommodation. Ms B is working in a supported employment programme. She also receives Disability Support Pension. Ms B has limited contact with her family who live interstate.

Effectiveness of previous treatment in ameliorating condition, effecting recovery, or preventing deterioration; history of non-compliance, subsequent relapse and consequences; effect of any current CTO:

Ms B has an excellent response to anti psychosis medication. When Ms B is on medication she only experiences symptoms during times of extreme stress (eg losing her job). Ms B however does not like to take medication and will cease this shortly after discharge from hospital. This has happened after the previous three admissions and has resulted in involuntary hospitalisations due to delusional ideas which lead to behaviour presenting a risk to others.

Duration of order requested (maximum 6 months for CTO and CCO):

A CTO of 6 month duration is requested.

Advantages of Community Order for safe, least restrictive possible care:

A CTO would ensure that Ms B maintains regular contact with her case manager and is in receipt of effective medication. This would therefore work toward preventing involuntary hospitalisations and is therefore the least restrictive form of care.

Rationale for Treatment Plan:

The Treatment Plan proposed aims to promote the following:

- regular contact with the case manager with the aim of working toward increasing rapport and a positive working relationship;
- regular review of medication and mental state to ensure the prescribed medication is the most suitable for Ms B's needs;
- cooperation with medication regime to assist with maintaining optimal mental health.

Attitude of patient/client, and relation/friends (if applicable) to application:

The application and Treatment Plan have been explained to Ms B and she is not in agreement with the application.

Applicant's signature:

Date:

Advice on the Mental Health Act

Centre for Mental Health

(02) 9391 9308

Mental Health Review Tribunal

(02) 9816 5955

Toll free: 1800 815 511

Mental Health Advocacy Service

(02) 9745 4277

Complaints and Concerns

Official Visitors' Program

(02) 9620 8218

NSW Health Care Complaints Commission

(02) 9219 7444

Toll free: 1800 043 159

Patient Support Office

Northern Sydney

(02) 9926 8184

South Eastern Sydney

(02) 9382 8129

Central Sydney

(02) 9767 8300

Western Sydney

(02) 9839 1506

Penrith/Blue Mountains

(02) 4724 3870

South Western Sydney

(02) 9828 5710

Hunter

(02) 4921 4943

Consumer and Carer Organisations

ARAFMI

(02) 9887 5897

NSW Association for Mental Health

(02) 9816 1611

NSW Consumer Advisory Group

(02) 9556 9219

Schizophrenia Fellowship of NSW

(02) 9878 2053

Guardianship

Guardianship Tribunal

(02) 9555 8500

Toll free: 1800 463 928

Public Guardian

(02) 9265 3184

Toll free: 1800 451 510

Protective Commissioner

(02) 9265 3131

Toll free: 1800 451 510

Cultural Issues

Transcultural Mental Health Centre

(02) 9840 3800

Toll free: 1800 648 911

